ORTHOPEDIC AND SPORTS INJURY SPECIALISTS

MEDICAL RECORDS RELEASE FORM

Please circle the information you would like released from the following:

COMPLETE RECORDS **Progress Notes** **Treatment Record** **OP Reports**
Radiology Reports **Pathology/Lab Reports** **Hospital Reports** **Medication Reports**
Other: _____

Please check the appropriate box below:

☐ Please release a copy of my medical records

TO:
OASIS Orthopedics
4461 Coit Road #211
Frisco, TX 75035
Phone: 972-335-8455
Fax: 972-335-7560

FROM: Address: _____
_____
_____
Phone: _____
Fax: _____

☐ Please release a copy of my medical records

TO: Address: _____
_____
_____
Phone: _____
Fax: _____

FROM:
OASIS Orthopedics
4461 Coit Road #211
Frisco, TX 75035
Phone: 972-335-8455
Fax: 972-335-7560

I understand that information will be provided within 15 days from the signed request and that a fee may be charged according to the rulings set forth by the Texas State Board of Medicine Examiners. By signing this form, I authorize you to release my confidential health information.

Patient name printed: _____

Signature: _____

Guardian (If under 18): _____

Patient Date of Birth: _____ Today's Date: _____